

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10201

Reg. Dist. No.

10211

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u> c. LENGTH OF STAY IN 1b <u>3 1/2</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>118 N. Main St</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>32 Bel Air</u> d. STREET ADDRESS <u>118 N Main St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ruth</u> First Middle Last 4. DATE OF DEATH <u>September 4</u> 19 <u>58</u> Month Day Year		5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>May 27-1922</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years and birthdays) <u>36</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>HARFORD CO MD</u> 11. BIRTHPLACE (State or foreign country) <u>U S</u> 12. CITIZEN OF WHAT COUNTRY? <u>U S</u>		13. FATHER'S NAME <u>Joseph H Ayres</u> 14. MOTHER'S MAIDEN NAME <u>Bessie Rinehart</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>NO</u> 16. SOCIAL SECURITY NO. <u>21-366-1121</u> 17. INFORMANT <u>Elizabeth A Kaplan</u> Address <u>Bel Air Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive CV disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald E Palmer</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>Gerald E Palmer</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>9-4-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> 22b. DATE THEREOF <u>Sept 8/58</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u> 22d. LOCATION (City, town, or county) (State) <u>Bel Air Harford Md</u>		24a. REC'D BY REGISTRAR <u>SEP 8 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 10202

10212

Item 1 Film G234 9/26/58 egg

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Addison Badders</u>		4. DATE OF DEATH <u>September 21</u> 19 <u>58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-10-75</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOSEPH BADDERS</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Melford Badden</u>		Address <u>White Hall Rd, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Angrene Small Intestine</u> <u>928.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Kicked in abdomen by cow</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>9-19-58</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>the farm</u>	20f. (City or town) <u>White Hall</u> (County) <u>Harford</u> (State) <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquity <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> 9-21-58 DATE SIGNED	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Bel Air Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-23-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FAUN GROVE METH.</u>		22d. LOCATION (City, town, or county) <u>Farm House, York Co., Pa.</u> (State) <u>Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth W. Fisher, Steeractatum, Pa.</u>		24a. REC'D BY REGISTRAR <u>SEP 23 '58</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form Page 5. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Medical & Dental Clinics: 1801 North
Wendover Street, Portland, ME 04106

CERTIFICATE OF DEATH

10203

Reg. Dist. No.

10236

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Alderdeen RD</u>		c. LENGTH OF STAY IN 1b <u>28 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ralph</u> First <u>Joseph</u> Middle <u>H-Beamer</u> Last		4. DATE OF DEATH <u>Sept 4</u> Month <u>4</u> Day <u>19</u> Year <u>68</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 9, 1904</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grading</u>	
11. BIRTHPLACE (State or foreign country) <u>Christiansburg, VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Rupert Lee Beamer</u>		14. MOTHER'S MAIDEN NAME <u>Dollie V. Peters</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-12-266</u>	
17. INFORMANT <u>Mrs Toy E Beamer</u>		Address <u>Alderdeen MD</u>	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> <u>464X</u> DUE TO (b) <u>Deep Phlebitis - bilateral</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>1 mos</u> <u>2 wks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>Aug 15</u> 19 <u>58</u> , to <u>Sept 3</u> 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 3</u> 19 <u>58</u> , and that death occurred at <u>1300</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ralph H. Hasky</u> M.D.		DATE SIGNED <u>Sept 4, 1958</u>	
PHYSICIAN'S NAME (Type) <u>Ralph H. Hasky MD</u>		<u>Churchville Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept 6-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion</u>	22d. LOCATION (City, town, or county) <u>Fountain Green</u> (State) <u>MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin E. Kutz</u>		ADDRESS <u>Laurel</u>	
24a. REC'D BY REGISTRAR <u>SEP 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraw</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, cause of death, and signatures of witnesses and the registrar.

1. Name of Deceased: [Faint handwritten text]

2. Date of Death: [Faint handwritten text]

3. Time of Death: [Faint handwritten text]

4. Place of Death: [Faint handwritten text]

5. Cause of Death: [Faint handwritten text]

6. Signature of Registrar: [Faint handwritten signature]

7. Signature of Witnesses: [Faint handwritten signatures]

TO ATTACH TO THE DEATH CERTIFICATE OF THE DECEASED, THIS CERTIFICATE MUST BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BUREAU OF VITAL STATISTICS, MARYLAND STATE DEPARTMENT OF HEALTH.

CERTIFICATE OF DEATH

10204

Reg. Dist. No.

10213

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harre de grace</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>24 Harre de grace</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>C.</i> Last <i>Brinkman</i>		4. DATE OF DEATH Month <i>September</i> Day <i>9</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 7 - 1884</i>
9. AGE (In years lost birthday) <i>74</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Unknown</i>	
11. BIRTHPLACE (State or foreign country) <i>Harre de grace, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>William Charles</i>		14. MOTHER'S MAIDEN NAME <i>Emma Davis</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Ruth Sheppard - Daughter</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adenocarcinoma, left breast</i> <i>170X</i> DUE TO <i>with metastasis.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Paralytic ileus, Terminal</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept 2nd</i> , 19 <i>58</i> , to <i>Sept 9th</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>Sept 9th</i> , 19 <i>58</i> , and that death occurred at <i>10:45 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Edward C. Loo</i>		ADDRESS (Street, city or town, state) <i>241 N. Union Ave. Harre de grace, Md.</i>	
PHYSICIAN'S NAME (Type) <i>Edward C. Loo, M.D.</i>		DATE SIGNED <i>Sept 9th 1958</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>9/12/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Angel Hill</i>	22d. LOCATION (City, town, or county) (State) <i>Harre de grace, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Anthony J. Harre de grace, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 16 '58</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be settled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10

10214

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE				c. LENGTH OF STAY IN 1b 17 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hosp.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 92 BELAIR			
f. STREET ADDRESS 1527 Rock Spring Rd.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Burkins Last Burkins				4. DATE OF DEATH Month September Day 20 Year 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 12-1881	
9. AGE (In years last birthday) 77 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) No Trade		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Vincent Burkins				14. MOTHER'S MAIDEN NAME Adama Jones			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 218-10-8712		17. INFORMANT MRS MAE B ADAMS 527 N. MAIN ST		Address Bel Air Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH Sudden 6-7 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Sept Day 20 Year 1958 Hour a. m. _____ p. m. _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 211 N. Union Ave.	
20f. (City or town) Bel Air				20g. (County) Harford		20h. (State) Md	
21. I certify that I attended the deceased from Sept 4th 1958 to Sept 20th 1958 , that I last saw the deceased alive on Sept 20th 1958 , and that death occurred at 130 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward C. Loo, M.D.				DATE SIGNED 9/20/58			
PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.				ADDRESS (Street, city or town, state) Haure de Grace, Ind			
22a. BURIAL, CREMATION, or other disposal (Specify) BURIAL		22b. DATE THEREOF Sept 23/58		22c. NAME OF CEMETERY OR CREMATORY Southern Methodist		22d. LOCATION (City, town, or county) (State) Dublin Harford Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph J. Foster				ADDRESS Bel Air Md		24a. REC'D BY REGISTRAR SEP 23 '58	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10215

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD	
c. LENGTH OF STAY IN 1b 8 HRS. 15 MINS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BEL AIR	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL HOSPITAL		d. STREET ADDRESS RD #2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LEONARD G Middle CLOMAN Last		4. DATE OF DEATH Month SEPTEMBER Day 13 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 24 '1884
9. AGE (In years lost birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Telephone Linesman		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE CLOMAN		14. MOTHER'S MAIDEN NAME MARGARET MILLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 212-050703	
17. INFORMANT (daughter) CATHERINE SCOTT		Address 204 S. BOND ST. BEL AIR, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chr Cardio-Vascular Disease 10yr DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Renal Failure; Diabetic Mellitus			
19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1953 , to Sept 13 1958 , that I last saw the deceased alive on Sept 13 1958 , and that death occurred at 1:50 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Willard P. Hudson		ADDRESS (Street, city or town, state) DATE SIGNED Forest Hill, Md 9/13/58	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF Sept 15/58	22c. NAME OF CEMETERY OR CREMATORY Mt Zion Methodist	22d. LOCATION (City, town, or county) (State) Fountain Green Harf. Rd Md
23. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Foster		24a. REC'D BY REGISTRAR DATE SEP 16 '58	24b. REGISTRAR'S SIGNATURE Carlton S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10216

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>203 E Penna Ave</u>		d. STREET ADDRESS <u>203 E Penna Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Beatrice Josephine Coniff</u>		DATE OF DEATH <u>September 23</u> 19 <u>58</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 22, 1895</u>
9. AGE (In years last birthday) <u>73</u> yrs		10. UNDER 1 YEAR <input type="checkbox"/> 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WAS Robt Mistress Theater</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NEW YORK N.Y.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Thomas McGarry</u>		14. MOTHER'S MARDEN NAME <u>Ada Fish</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>054-01-9598</u>	
17. INFORMANT <u>Mrs. Theodore P. Stein</u>		Address <u>203 E Penna Ave Bel Air Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> 9-23-58 DATE SIGNED	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Bel Air Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>Sept. 26, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Ignatius Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hickory, Harford Co., Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u> ADDRESS <u>W. Broadway + Williams St. BEL Air, Maryland</u>		24a. REC'D BY REGISTRAR <u>DA SEP 25 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

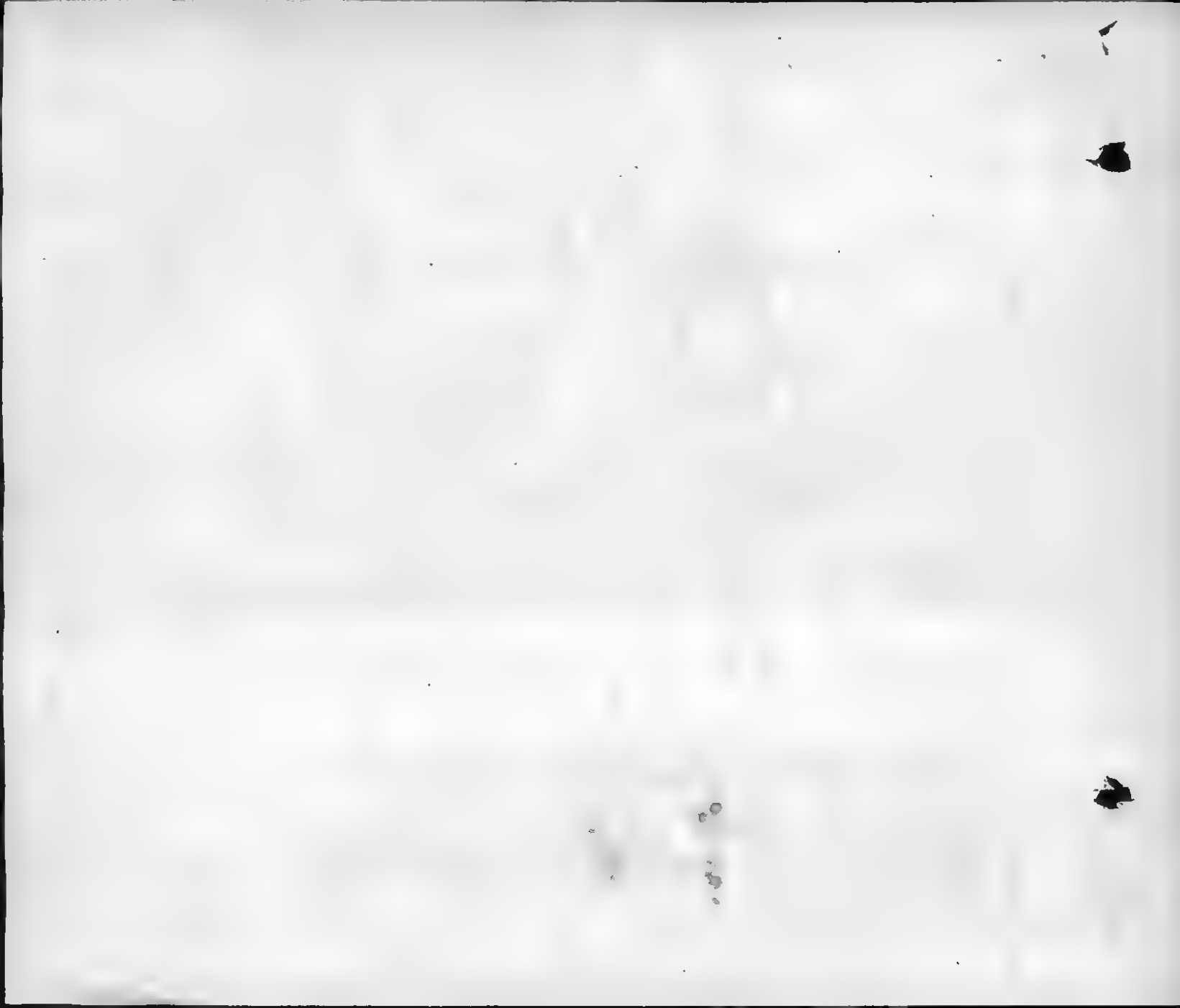
10217

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hanford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrods Creek</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hanford Memorial Hospital</u>		d. STREET ADDRESS <u>630 North Point Road</u>	
3. NAME OF DECEASED (Type or print) <u>STANLEY R. COURTS</u>		4. DATE OF DEATH <u>September 28</u> 19 <u>58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 4-1903</u>
9. AGE (In years, last b. (day) <u>54</u> yrs		10. IF UNDER 1 YEAR <u>11</u> Months <u>11</u> Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STEEL WORKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BETH. STEEL</u>	
11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Albert Courts</u>		14. MOTHER'S MAIDEN NAME <u>Abbie Ingram</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>233-67-4976</u>	
17. INFORMANT <u>Ruth Courts</u>		Address <u>630 North Pt Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>L.S.W. Cerebrum</u> <u>976X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last, (c) _____ DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Shot self with pistol</u>	
20c. TIME OF INJURY Month Day, Year <u>9-28</u> 19 <u>58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Franklinville Balto.</u>		20f. (City or town) (County) (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bel Air, MD	
EXAMINER'S NAME (Type) <u>Gerald C Palmer - MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>9-28-58</u>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 2-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		22d. LOCATION (City, town, or county) (State) <u>Eastern Ave. Bldg.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connelley Essex - Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 29 '58</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10237

CERTIFICATE OF DEATH

10209

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air R.D.,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air, R.D.,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS Creswell	
3. NAME OF DECEASED (Type or print) First Middle Last William E. Daugherty		4. DATE OF DEATH Month Day Year Sept. 1, 19 58	
5. SEX male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 10, 1890
9. AGE (In years last birthday) yrs 67		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor	
10b. KIND OF BUSINESS OR INDUSTRY Church		11. BIRTHPLACE (State or foreign country) Harford Co., Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John F. Daugherty	
14. MOTHER'S MAIDEN NAME Frances Ruff		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. 212-32-6059		17. INFORMANT Edna C. Daugherty, Address Bel Air R.D., Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Pancreas 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8/16 , 19 58 , to 8/30 , 19 58 , that I last saw the deceased alive on 8/30 , 19 58 , and that death occurred at 10:52 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED George T. Stansbury, M.D. 569 Revolution St., Havre de Grace, Md 9/3/58 ACTUAL SIGNATURE George T. Stansbury PHYSICIAN'S NAME (Type) George T. Stansbury 569 Revolution St., Havre de Grace, Md.,			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 4, 1958	22c. NAME OF CEMETERY OR CREMATORY John Wesley	22d. LOCATION (City, town, or county) (State) Abingdon, Harford, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Howard R. Williams Jr		24a. REC'D BY REGISTRAR DATE SEP 8 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10210

10218

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrode Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>473 N St. SW</u>	
3. NAME OF DECEASED (Type or print) <u>Willie Clarence De Board</u>		4. DATE OF DEATH <u>September 6 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-7-12</u>
9. AGE (In years last birthday) <u>46</u> yrs		10. IF UNDER 1 YEAR <u>46</u> Months Days Hours M n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Pete De Board</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Bellie De Board</u>		Address <u>473 N. St. SW</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fracture Skull</u>			
812X DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture R femur</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>fall</u>	
20c. TIME OF INJURY Month, Day, Year <u>9-6-58</u>		20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Harrode Grace</u> (County) <u>Harford</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air Md</u> DATE SIGNED <u>9-6-58</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>9/8/58</u>		22b. DATE THEREOF <u>Unknown</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Unknown</u>		22d. LOCATION (City, town, or county) <u>Oliver Hill</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Parryton Sm. Harrode Grace, Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 10 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krasner</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10211

10238

Reg. Dist. No.

1 PLACE OF DEATH a COUNTY <u>Harford</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, If institution Residence before admission) a STATE <u>MD</u> b COUNTY <u>Harford</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>		c. LENGTH OF STAY IN 1b <u>1 month</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		4 STREET ADDRESS <u>Joppa</u>	
3. NAME OF DECEASED (Type or print) <u>Sheena Raye Epps</u>		4. DATE OF DEATH <u>September 20 19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>E</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-21-58</u>
9. AGE (In years last birthday) <u>1</u>		IF UNDER 1 YEAR <u>1</u> Days <u>1</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11 BIRTHPLACE (State or foreign country) <u>Baltimore, Md.,</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Willie Epps</u>		14. MOTHER'S MAIDEN NAME <u>Mildred Cohen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT <u>Willie Epps,</u>		Address <u>Joppa, Maryland.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastroenteritis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		DATE SIGNED <u>9-20-58</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept. 21, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Community Baptist</u>	22d. LOCATION (City, town, or county) (State) <u>Joppa, Harford, Maryland.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard R. Williams Jr</u>		24a. REC'D BY REGISTRAR <u>Abingdon Maryland.</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>		DATE SEP 24 '58	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the State Board of Health. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No. 10212

10219

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>				c. LENGTH OF STAY IN 1b <u>45 HRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSP.</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Whiteford</u>			
f. STREET ADDRESS <u>1</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>DEBRA</u> Middle <u>JOYCE</u> Last <u>FEW</u>				4. DATE OF DEATH Month <u>SEPTEMBER</u> Day <u>10</u> Year <u>1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 8, 1958</u>	
9. AGE (In years last birthday) <u>1 1/2</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>15</u>		11. IF UNDER 24 HRS. Hours <u>1</u> Min. <u>15</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>William Edward Few</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Canther</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>William E. Few, Whiteford, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary atelectasis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>—</u>			
20c. TIME OF INJURY Hour <u>—</u> o. m. <u>—</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that I attended the deceased from <u>9/8</u> , 19 <u>58</u> , to <u>9/10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9/10</u> , 19 <u>58</u> , and that death occurred at <u>4:45</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dudley Phillips</u> M.D.				ADDRESS (Street, city or town, state) <u>Washington Md</u>		DATE SIGNED <u>9/11/58</u>	
PHYSICIAN'S NAME (Type) <u>Dudley Phillips M.D.</u>				ADDRESS <u>Washington Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9-11-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BRYANSVILLE</u>		22d. LOCATION (City, town, or county) (State) <u>BRYANSVILLE YORK CO., PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Harkin, Delta, Pa.</u>				ADDRESS <u>—</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 15 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kross</u>				24c. REGISTRAR'S SIGNATURE <u>—</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2071191XV5



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE				c. LENGTH OF STAY IN 1b 6 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hosp.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE			
f. STREET ADDRESS 515 FRANKLIN				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Amos Middle Gibson Last Gibson				4. DATE OF DEATH Month SEPTEMBER Day 16 Year 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 1-1891	
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR: Months 6 Days 16 Hours 19 Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REPAIRING + REFINISHING FURNITURE				10b. KIND OF BUSINESS OR INDUSTRY MARYLAND		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Franklin Gibson				14. MOTHER'S MAIDEN NAME Mary Hamilton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT Teller C. Gibson, 515 Franklin St. Harford, Md.				18. ADDRESS (Street, city or town, state) 515 Franklin St. Harford, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Malignant Lymphoma DUE TO (Lymphoblastic type) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) —							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) —			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. —				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	
20f. (City or town) —		(County) —		(State) —			
21. I certify that I attended the deceased from Jan 20th, 1958 to Sept 16th, 1958 that I last saw the deceased alive on Sept 16th, 1958 and that death occurred at 5:45 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward C. Loo, M.D.				ADDRESS (Street, city or town, state) 211 N. Union Ave. Harford, Md.			
DATE SIGNED Sept 16th, 1958							
PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.				Harford, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) 9/19/58		22b. DATE, THEREOF 9/19/58		22c. NAME OF CEMETERY OR CREMATORY Rose Bank		22d. LOCATION (City, town, or county) (State) Cherry Hill Md	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kraus				ADDRESS Harford, Md.		24a. REC'D BY REGISTRAR SEP 18 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement that the death certificate be executed within 4 hours after death, Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. The registrars remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

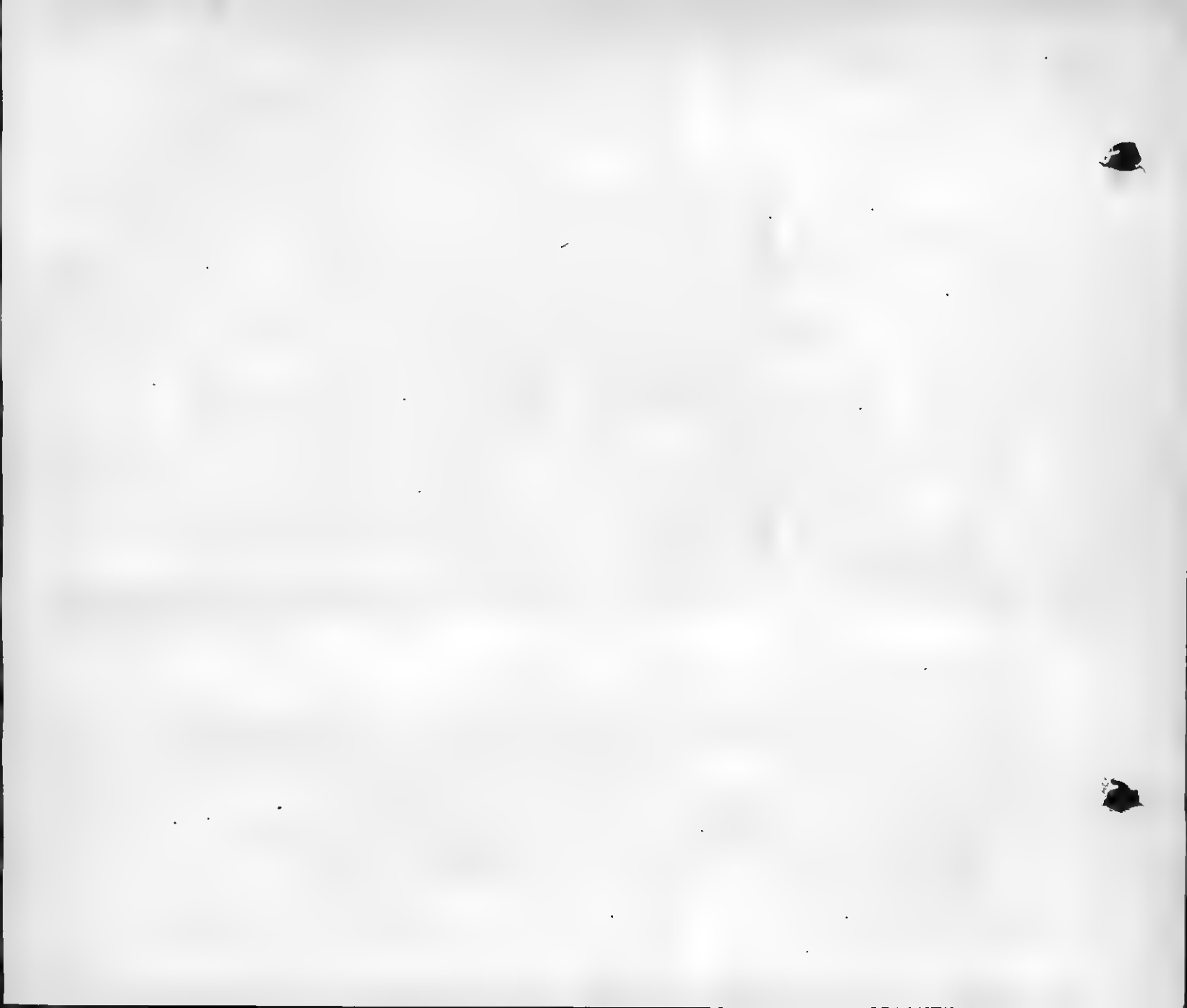
10214

10221

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If inst. tuition Residence before admission) a. STATE <u>Penna</u> b. COUNTY <u>Dauphin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middletown</u>	
c. LENGTH OF STAY IN 1b <u>-</u>		d. STREET ADDRESS <u>R. F. W.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Thurman B. Good</u>		4. DATE OF DEATH <u>September 12 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-9-05</u>
9. AGE (in years last birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Owner</u>	
11. BIRTHPLACE (State or foreign country) <u>Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Albert Good</u>		14. MOTHER'S MAIDEN NAME <u>Bernah Brinker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>-</u>	
17. INFORMANT <u>Mrs. Thurman Good</u>		Address <u>Middletown, Pa. R.F.W.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>2nd degree burns 50% body area</u> <u>858X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ causing the underlying cause last. (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Gasoline fire on his boat</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>9-10</u> p. m. <u>1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>Wharf</u>		(County) <u>Dauphin</u> (State) <u>Pa.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>9-12-58</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-15-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cem.</u>		22d. LOCATION (City, town, or county) <u>Middletown, Pa. R.F.W.</u> (State) <u>Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Patterson & Son, Bryn Mawr, Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 15 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. L. Howard</u>			



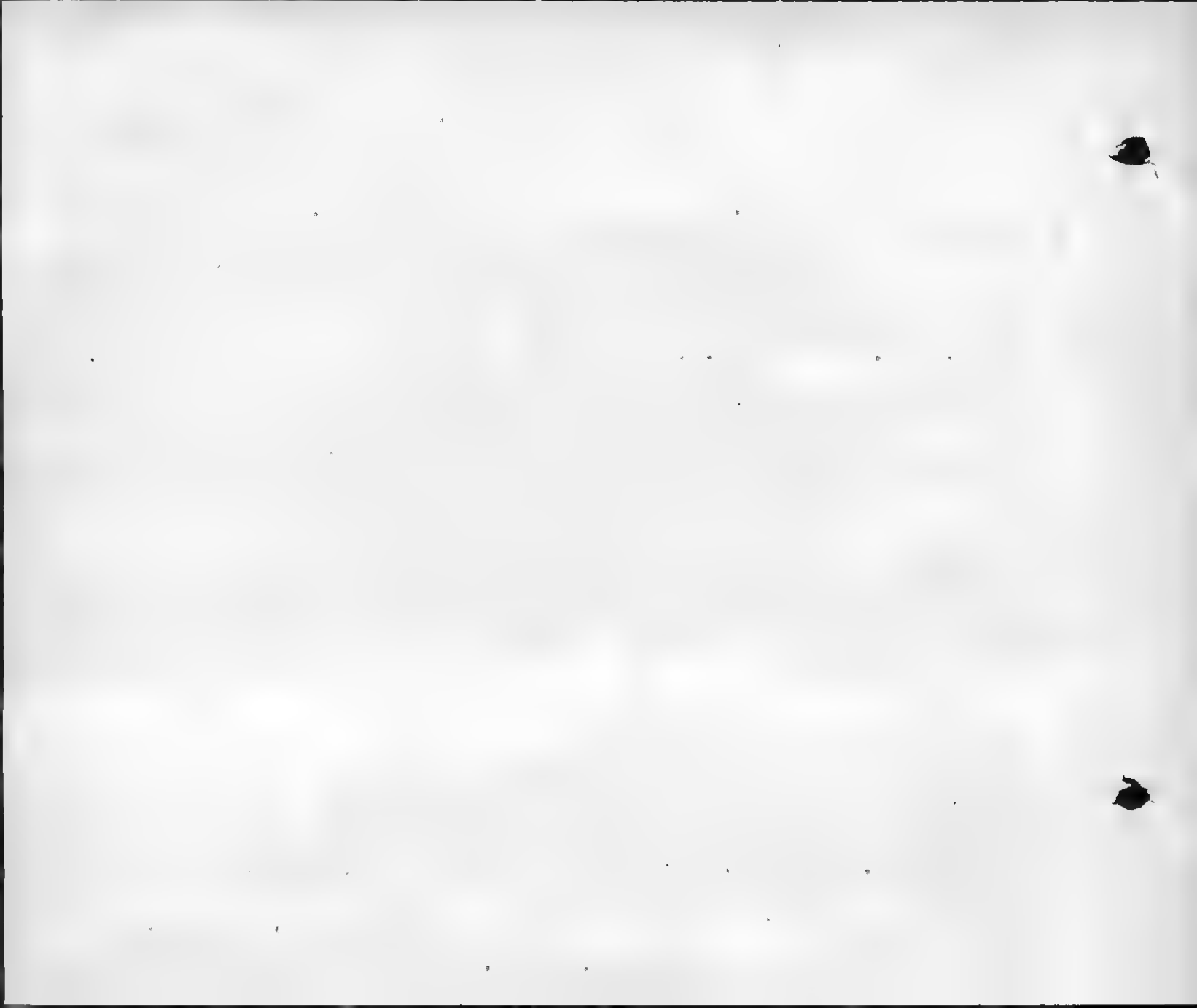
10239

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cardiff				c. LENGTH OF STAY IN 1b 31 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Chestnut St.				e. STREET ADDRESS Chestnut St.			
3. NAME OF DECEASED (Type or print) First LYLE Middle DICK Last HAMILTON				4. DATE OF DEATH Month Sept. Day 14 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 5, 1927	
9. AGE (In years last birthday) 31 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tech. Sgt.		11. BIRTHPLACE (State or foreign country) Cardiff, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Raymond Hamilton				14. MOTHER'S MAIDEN NAME Gurnice Dick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 1945-1958		17. INFORMANT Raymond Hamilton, Cardiff, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 178x Metastatic Carcinoma							
DUE TO (b) Primary adenocarcinoma of the							
DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from July 1958 to Sept 14, 1958 , that I last saw the deceased alive on Sept 13, 1958 , and that death occurred at 5:30 M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Josiah A. Hunt				ADDRESS (Street, city or town, state) Delta, Penna.		DATE SIGNED Sept. 15, 1958	
PHYSICIAN'S NAME (Type) Dr. Josiah A. Hunt				Delta, Penna.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-17-1958		22c. NAME OF CEMETERY OR CREMATORY Slate Ridge		22d. LOCATION (City, town, or county) (State) Delta, York Co., Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Harkins				ADDRESS Delta, Penna.		24a. REC'D BY REGISTRAR SEP 17 58	
						24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10222

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryman</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>		d. STREET ADDRESS <u>Box 15</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Jacob Hammel</u>		4. DATE OF DEATH Month Day Year <u>9 13 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>20 March 1890</u>
9. AGE (In years last birthday) yrs. <u>68</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>R.R. Watchman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Charles Edward Hammel</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Welch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>717-09-5394</u>	
17. INFORMANT <u>Bertha Hammel</u>		Address <u>Perryman Md Box 15</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>445x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Hypertensive-Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Cerebral Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Thrombosis</u> <u>Severe Anemia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/7</u> , 19 <u>58</u> , to <u>9/13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9/13</u> , 19 <u>58</u> , and that death occurred at <u>7:05 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>509 Revolution St., Hartford-de-Grace, Md.</u> <u>9/14/58</u>			
ACTUAL SIGNATURE <u>George J. Stansbury</u>		M.D. <u>St. 9 Revolution St., Hartford-de-Grace, Md.</u>	
PHYSICIAN'S NAME (Type) <u>George J. Stansbury</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/16/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>	22d. LOCATION (City town or county) (State) <u>Bel Air, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarring</u>		ADDRESS <u>Aberdeen, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 17 58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur P. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



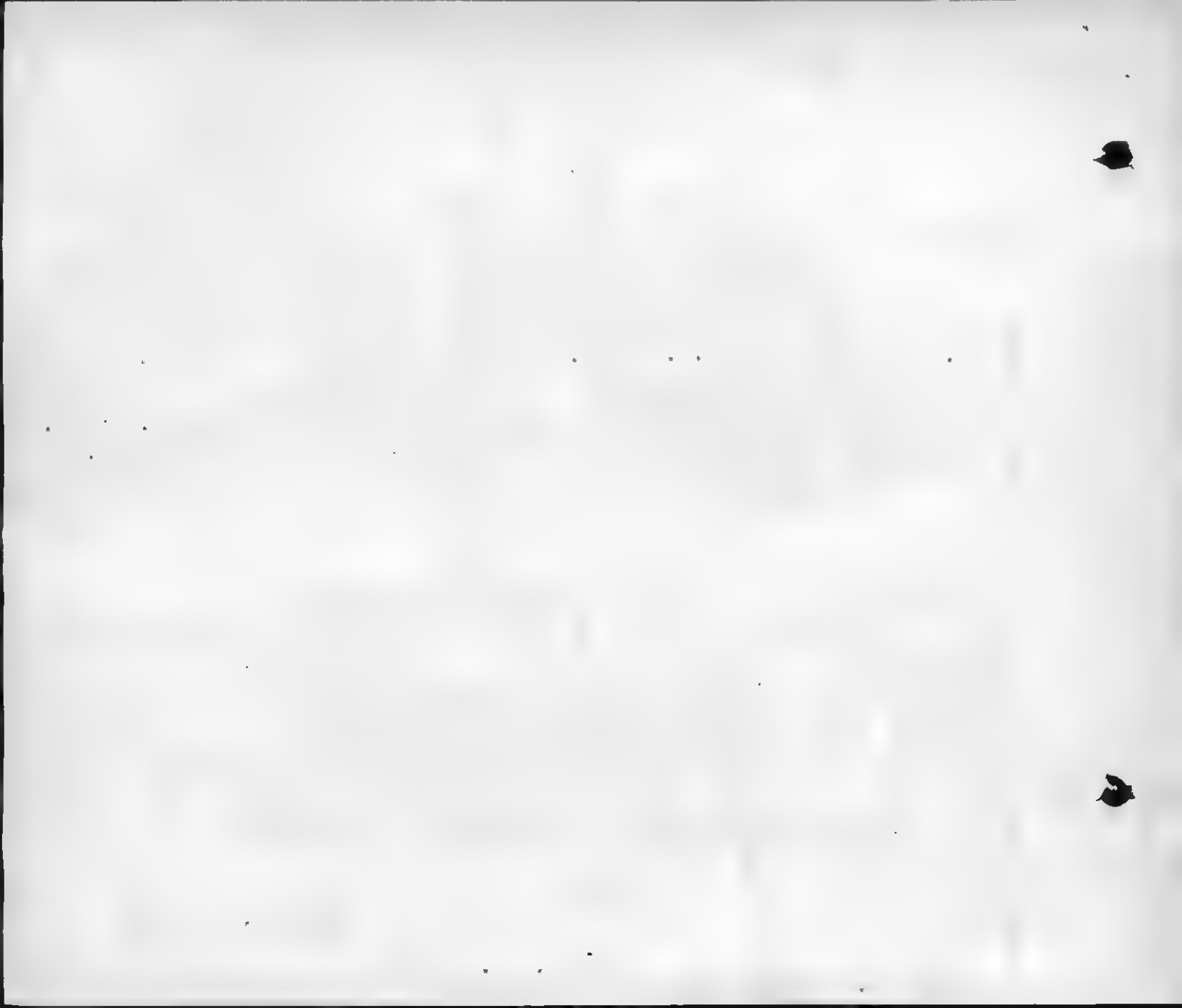
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10223 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 10217

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Hampden Trace</u>		c. LENGTH OF STAY IN 1b <u>26 yrs</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>404 Phila Blvd</u>	
3. NAME OF DECEASED (Type or print) <u>JAMES WILLIAM HARTE</u>		4. DATE OF DEATH <u>September 18 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-3-30</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lab. Technician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't.</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Peter John Harte (Deceased)</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Morris</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>Korean</u>		16. SOCIAL SECURITY NO. <u>214 26 7179</u>	
17. INFORMANT <u>Katherine M. Harte</u>		Address <u>404 S. Phila. Aberdeen, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull</u> <u>16X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture both lower R leg</u>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Autoaccident auto auto type</u>	
20c. TIME OF INJURY Month, Day, Year <u>16 9-16 58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>25 Route 40</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bel Air Md. DATE SIGNED <u>9-19-58</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer-MD</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/23/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarring</u>		ADDRESS <u>Aberdeen, Md.</u>	
24a. REC'D BY REGISTRAR <u>SEP 23 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



10224

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>PA.</u> b. COUNTY <u>BUCKS</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COOPERSBURG RD#1</u>		d. STREET ADDRESS <u>PASSER RD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD MEMORIAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>HARRISON</u> Middle <u>EUGENE</u> Last <u>HUDSON</u>				4. DATE OF DEATH Month <u>SEPT</u> Day <u>14</u> Year <u>1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT 5, 1903</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LINE MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ELECTIC CO</u>		11. BIRTHPLACE (State or foreign country) <u>NO. CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>THOMAS HUDSON</u>				14. MOTHER'S MAIDEN NAME <u>LUCY J. BRAKEFIELD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>164 014595</u>		17. INFORMANT Address <u>DOROTHY HUDSON</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH <u>1 MINUTE</u>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MASSIVE CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u> </u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Philip W. Hedman</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>PHILIP W. HEDMAN</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Buried</u>		<u>Sept 15, 1958</u>		<u>Forest Grove Burying Co</u>		<u>Perman</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Asst Bailey</u>				ADDRESS <u>Harlington Md</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 16 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Criss L. Hume</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to it. Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



10225

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>105 N. Washington</i>	
3. NAME OF DECEASED (Type or print) <i>Laura Anthony Hughes</i>		4. DATE OF DEATH <i>9/25/58</i> 19 <i>58</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 7-1871</i>
9. AGE (In years last birthday) <i>87</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>Gunpton, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Johannathan Anthony</i>		14. MOTHER'S MAIDEN NAME <i>Mary Louisa Robinson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>Mary Hughes</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Emergency</i>		INTERVAL BETWEEN ONSET AND DEATH	
420.0 DUE TO <i>arterio Sclerotic Heart Disease</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Blind for several years</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <i>58</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>6-13</i> , 19 <i>53</i> to <i>5-23</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>6/23</i> , 19 <i>58</i> , and that death occurred at <i>7:30</i> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>C. L. ...</i>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>Harold ...</i>			
22a. BURIAL CREMATION, REMOVAL (Specify) <i>9/27/58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Angel Hill</i>	
22b. LOCATION (City, town, or county) <i>Harford</i>		22d. LOCATION (City, town, or county) <i>Harford</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>...</i>		24a. REC'D BY REGISTRAR DATE <i>OCT 1 '58</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur L. ...</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

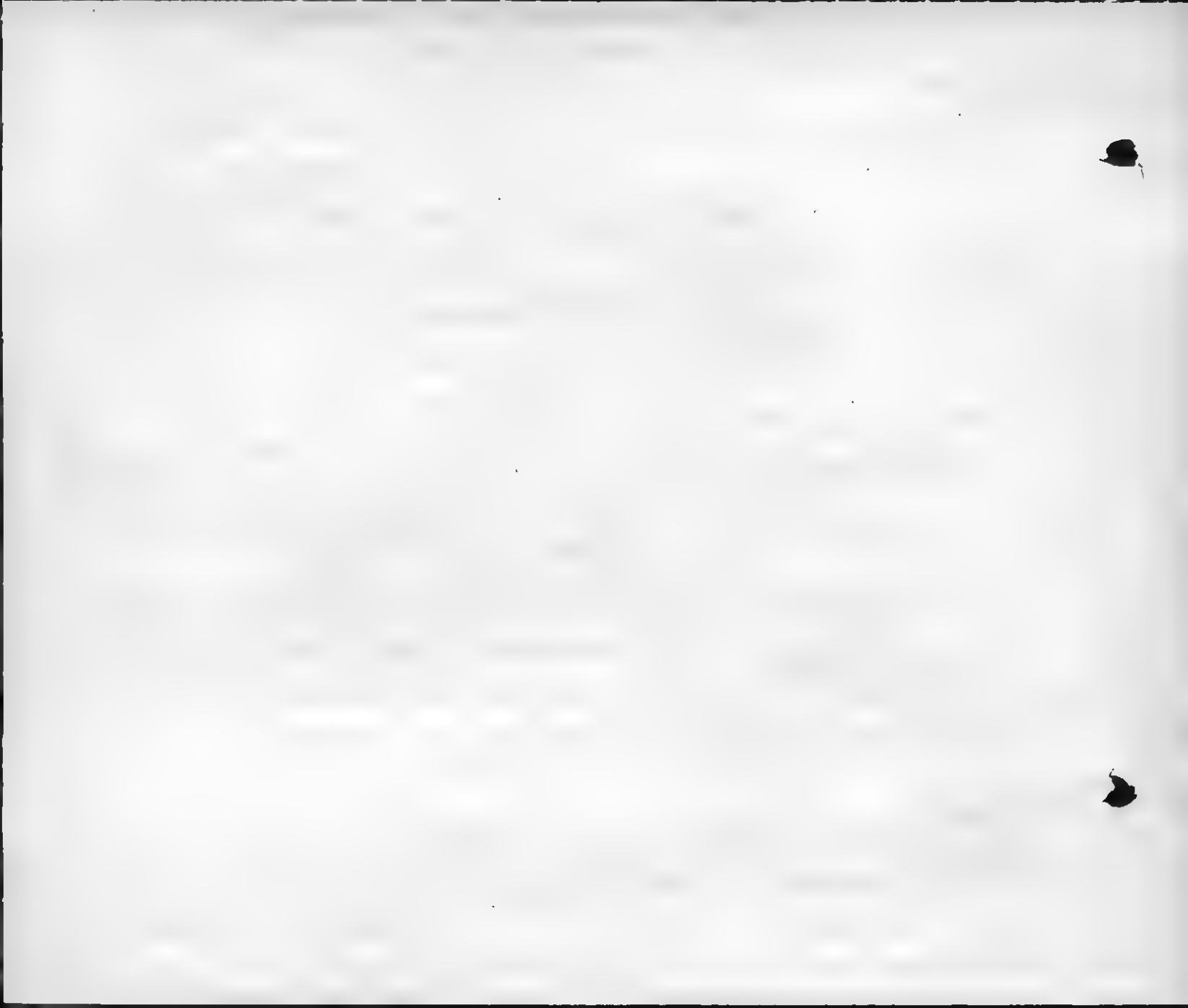
10226

CERTIFICATE OF DEATH

Reg. Dist. No. 10220

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HARVE DE GRACE		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Scott Lewis Kaylor		4. DATE OF DEATH September 25 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPTEMBER 22 58
9. AGE (In years last birthday) 4		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN THOMAS KAYLOR		14. MOTHER'S MAIDEN NAME DAWN SANDRA KAYLOR	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Barb Rends Harford Chase, MD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hemorrhage 7695 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Perinatal - 34 wk gestation DUE TO Spontaneous abortion (c) Spontaneous abortion			INTERVAL BETWEEN ONSET AND DEATH minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9/22, 1958 to 9/25, 1958 that I last saw the deceased alive on 9/25, 1958 , and that death occurred at 11:01 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Harford Chase, MD DATE SIGNED 9/26/58			
ACTUAL SIGNATURE [Signature] M.D.		PHYSICIAN'S NAME (Type) [Signature]	
22a. BURIAL, CREMATION, REMOVAL (Specify) 711011XV2	22b. DATE THEREOF 9/27/58	22c. NAME OF CEMETERY OR CREMATORY Angel Hill	22d. LOCATION (City, town, or county) (State) Harford Chase MD
23. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS Harford Chase, MD		24a. REC'D BY REGISTRAR OCT 1 '58	24b. REGISTRAR'S SIGNATURE Arthur L. Turner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10221

Reg. Dist. No.

10227

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>32 Bel Air</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		1. STREET ADDRESS <u>1 Dallam Place</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>O.</u> Last <u>Lee</u>		4. DATE OF DEATH Month <u>September</u> Day <u>11</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 22 - 1886</u>
9. AGE (In years last birthday) <u>72</u> yrs		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Bookkeeper</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>William Lee</u>		14. MOTHER'S MAIDEN NAME <u>Josephine OREM</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>215-01-3995</u>	
17. INFORMANT <u>Mrs Charles Chan</u> Address <u>98 Dallam Place Bel Air Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> DUE TO <u> </u> (c) <u> </u> DUE TO <u> </u> [a], stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> (b) <u> </u> (c) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald E Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air</u> DATE SIGNED <u>9-11-58</u>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>WJ</u>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 14/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Churchville Presbyterian</u>		22d. LOCATION (City, town, or county) (State) <u>Churchville Harford Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Foster</u> ADDRESS <u>Bel Air Md</u>		24a. REC'D BY REGISTRAR <u>SEP 15 58</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>S. Thomas</u>	

MEDICAL CERTIFICATION



10228

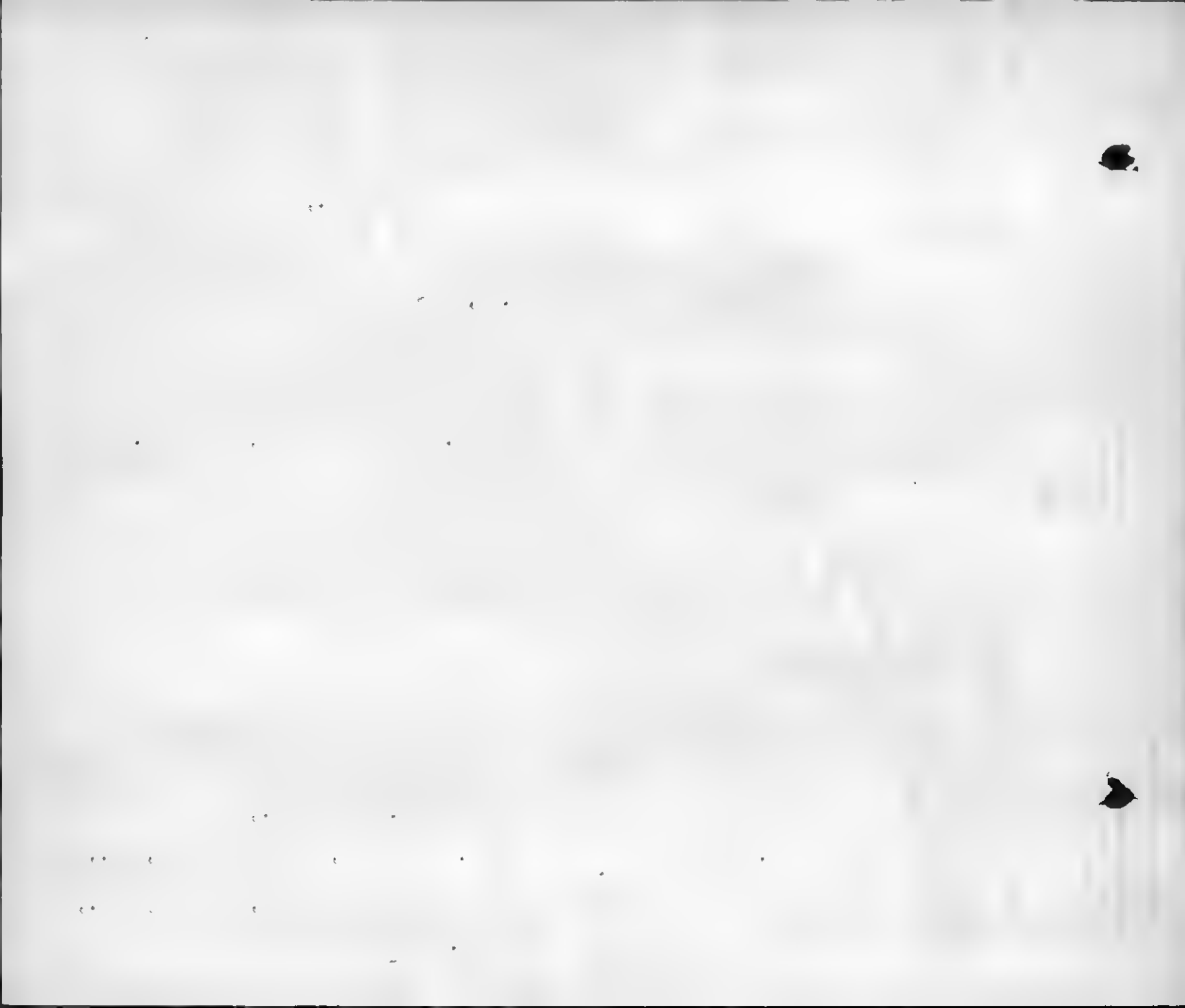
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. LENGTH OF STAY IN 1b <u>1 Hr 45 min</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Harford Mem. Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>	
3. NAME OF DECEASED (Type or print) First <u>Betty</u> Middle <u>Sue</u> Last <u>Nester</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 21, 1958</u>
9. AGE (In years last birthday) yrs. <u>14</u>		10. IF UNDER 1 YEAR Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Arnold Elmo Nester</u>		14. MOTHER'S MAIDEN NAME <u>Thelma Jun Primm</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT <u>Arnold E. Nester, Joppa, Maryland.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Aspiration</u> <u>768.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Septicemia</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/31</u> , 19 <u>58</u> , to <u>9/5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8:45 AM 9/5</u> , 19 <u>58</u> , and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Theodore H. Kaiser</u> M.D.		ADDRESS (Street, city or town, state) <u>419 S. Union Ave.,</u> DATE SIGNED <u>9/5/1958</u>	
PHYSICIAN'S NAME (Type) <u>Theodore H. Kaiser</u>		<u>419 S. Union Ave, Havre de Grace, Md.,</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/7/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	22d. LOCATION (City, town, or county) (State) <u>Hillsville, Carroll, Va.,</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard R. McComas Jr</u>		ADDRESS <u>Abingdon, Maryland</u>	24a. REC'D BY REGISTRAR DATE <u>SEP 8 '58</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10223

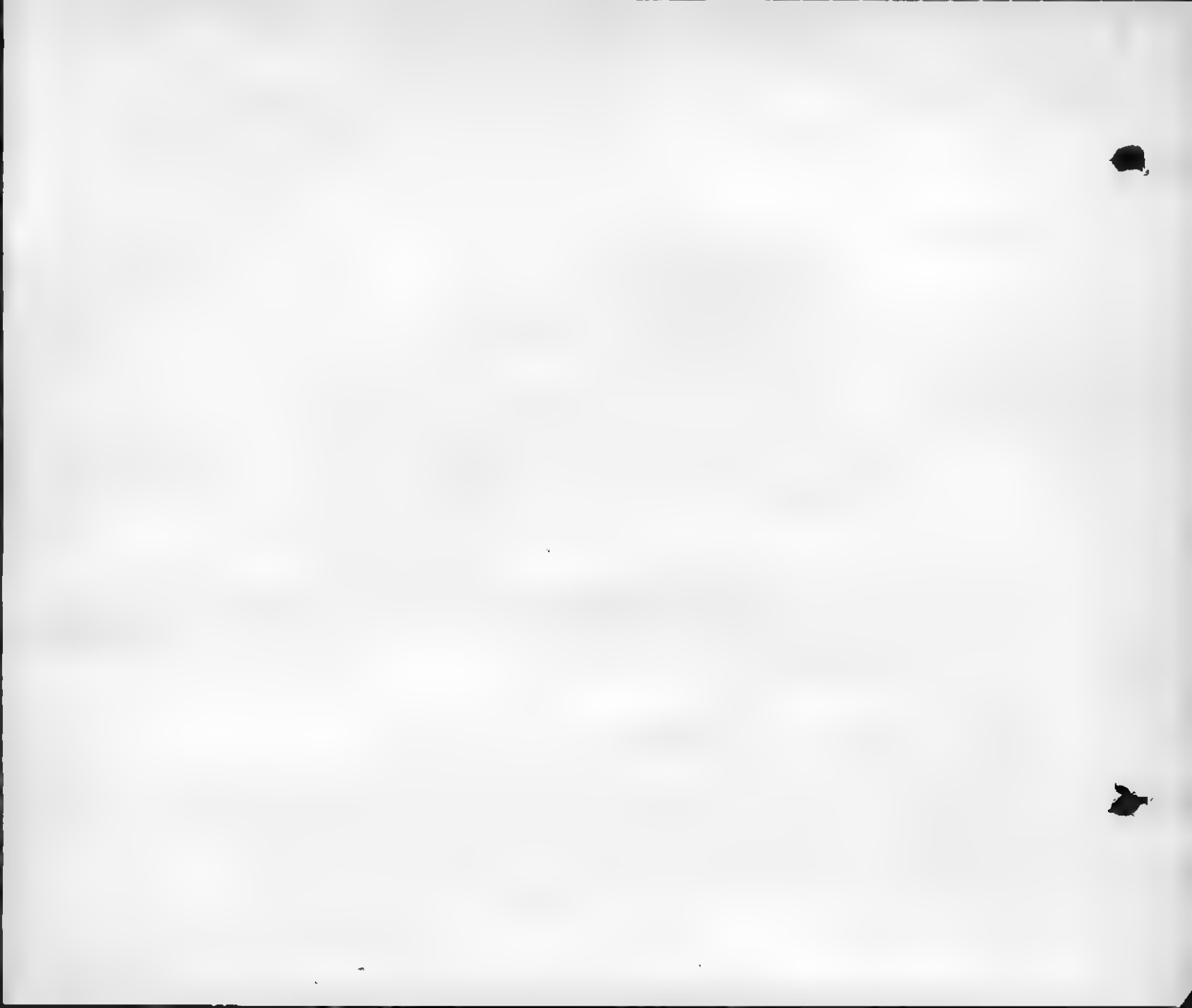
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. LENGTH OF STAY IN 1b <u>144 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		d. STREET ADDRESS <u>619 Fountain</u>	
3. NAME OF DECEASED (Type or print) <u>John H. Poplar</u>		4. DATE OF DEATH <u>9/19/58</u> 19 <u>58</u>	
5. SEX <u>Male</u>	6. COLOR OF RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/15/1864</u>
9. AGE (In years, last birthday) <u>94</u> yrs		10. IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done, bearing most of working life, even if retired) <u>Insurance agent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford County, Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Poplar</u>		14. MOTHER'S MAIDEN NAME <u>Effie Russell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>W. Monroe Fox</u> Address <u>Harford County, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO <u>cerebral apoplexy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>1 yr</u> <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/19/58</u> , 19 <u>58</u> , to <u>9-19</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9/19</u> , 19 <u>58</u> , and that death occurred at <u>6:30 A.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. J. Simon</u> M.D.		ADDRESS (Street, city or town, state) <u>Harford Co. Md.</u> DATE SIGNED <u>—</u>	
PHYSICIAN'S NAME (Type) <u>E. J. SIMON</u>		<u>LAURE DE GRACE</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>9/21/58</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Harford Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Harford County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>—</u> ADDRESS <u>Harford County, Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 25 '58</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>—</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10240

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel-air Rural 2070</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Street, Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Walter Nursing Home Bel Air, Md.</u>		d. STREET ADDRESS	
3 NAME OF DECEASED (Type or print) <u>Edwin H. Price</u>		4. DATE OF DEATH <u>Sept. 10, 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 29, 1877</u>
9. AGE (In years last birthday) <u>81</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTH-PLACE (State or foreign country) <u>Harford Co., Md., U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME <u>David E. Price</u>		14. MOTHER'S MAIDEN NAME <u>Mary Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>No</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO <u>mw</u>	
17. INFORMANT <u>David E. Price</u> Address <u>Street Harford Co., Md.</u>			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Memia</u> DUE TO <u>Carcinoma of Prostate</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>21 days</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 14, 1955</u> , to <u>Sept 10, 1958</u> , that I last saw the deceased alive on <u>Sept 8, 1958</u> , and that death occurred at <u>330 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dudley Phillips MD</u> M.D.		ADDRESS (Street, city or town, state) <u>Washington Md</u>	
PHYSICIAN'S NAME (Type) <u>Dudley Phillips MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Sept 13, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Harlington Co., Harford Co., Md.</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u> ADDRESS <u>Harlington Co., Md.</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <u>C. S. Hines</u>
		DATE <u>SEP 15 '58</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10225

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Harford</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Harre de Grace</u> LENGTH OF STAY (in this place) <u>12 days</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Cecil</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Colora</u> STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>Minor (Nellie McVey) Rawlings</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>9-20-1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>12-8-1888</u>
9. AGE last birthday <u>69</u> yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Practical Nurse</u>	
11. BIRTHPLACE (State or foreign country) <u>Cecil-Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Frances Fla Harty</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-34-0656</u>	
17. INFORMANT & ADDRESS <u>Mrs. Elbert Copenhaver</u>		<u>Colora Md.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		16. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Myocardial Infarction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinomatosis</u>		<u>1 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Sept 8</u> , 19 <u>58</u> , to <u>9/20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 20</u> , 19 <u>58</u> , and that death occurred at <u>1:40 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Neil Taylor</u> M.D.		ADDRESS (Street, city, town, state) <u>Rising Sun, Md.</u> DATE SIGNED <u>9/22/58</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept 23, 58</u> NAME OF CEMETERY OR CREMATORY <u>West Nottingham</u> LOCATION (City, town, or county) <u>Colora Md.</u> (State)	
24. REC'D BY REGISTRAR <u>SEP 24 '58</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. Earl Tyson</u> ADDRESS <u>Rising Sun, Md.</u>	



10231

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harre de Grace</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harre de Grace</i>	
c. LENGTH OF STAY IN 1b <i>Lifetime</i>		d. STREET ADDRESS <i>730 Otsego Street</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>730 Otsego Street</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Julia</i> Middle <i>A.</i> Last <i>Ridgely</i>		4. DATE OF DEATH Month <i>9</i> Day <i>17</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-30-1876</i>
9. AGE (In years last birthday) <i>82 yrs.</i>		IF UNDER 1 YEAR Months <i>4</i> Days <i>17</i>	IF UNDER 24 HRS Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	
11. BIRTHPLACE (State or foreign country) <i>Harford Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Joseph Collins</i>		14. MOTHER'S MAIDEN NAME <i>Sabina Gilbert</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Mrs. Elva N. Johnson</i>		Address <i>730 Otsego St. Harre de Grace, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i></i> DUE TO (c) <i>Hypertensive-Atherosclerotic Heart Disease</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>4/16</i> , 19 <i>51</i> , to <i>9/16</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>9/16</i> , 19 <i>58</i> , and that death occurred at <i>8:15 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>George T. Stansbury</i>		ADDRESS (Street, city or town, state) <i>569 Revolution St., Harre de Grace, Md.</i>	
PHYSICIAN'S NAME (Type) <i>George T. Stansbury</i>		DATE SIGNED <i>9/18/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9-20-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Green Spring</i>	22d. LOCATION (City, town, or county) (State) <i>Harford Co. Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Otelia J. Bullock</i>		ADDRESS <i>Harre de Grace</i>	
24a. REC'D BY REGISTRAR <i>SEP 22 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Farris</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

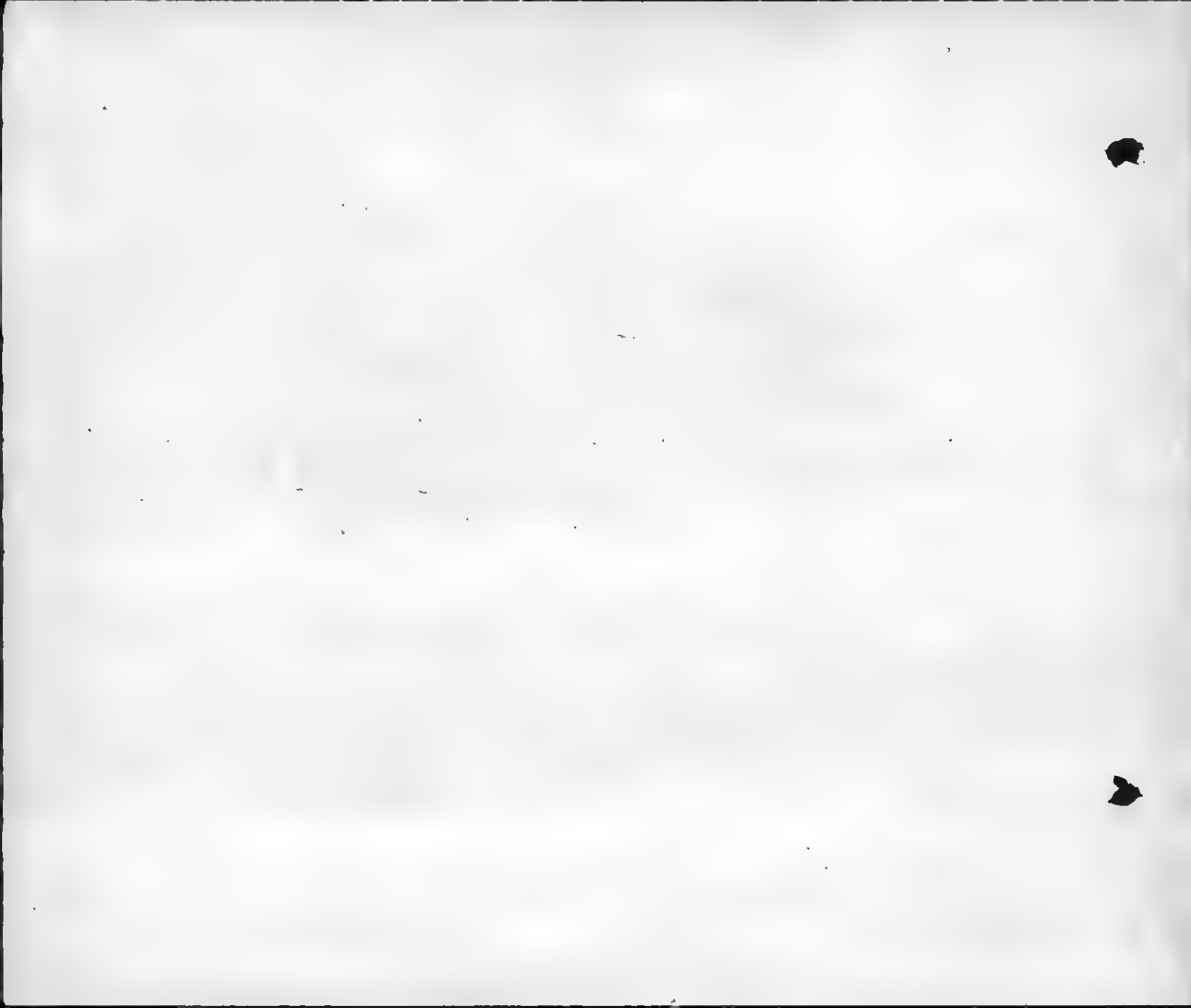
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10232 CERTIFICATE OF DEATH

10227

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>R.D. # 3</u>	
3. NAME OF DECEASED (Type or print) First <u>WILLIS</u> Middle <u>Rogers</u> Last <u>Rogers</u>		4. DATE OF DEATH Month <u>9</u> Day <u>10</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-23-1912</u>
9a. AGE (In years lost birthday) <u>46</u> yrs		9b. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Excavator</u>	
11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>C.R. Rogers</u>		14. MOTHER'S MAIDEN NAME <u>Minnie L. Cox</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>249-07-2888</u>	
17. INFORMANT <u>Mrs. Willis Rogers</u>		Address <u>Elton Md. R.D. #3</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> <u>4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>coronary thrombosis</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1952</u> , 19 <u> </u> , to <u>9/10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9/10</u> , 19 <u>58</u> , and that death occurred at <u>7 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Neil Taylor</u> M.D.		ADDRESS (Street, city or town, state) <u>Rising Sun, Md.</u>	
DATE SIGNED <u>9/11/58</u>			
PHYSICIAN'S NAME (Type) <u>Neil Taylor Jr.</u>		<u>Rising Sun, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-14-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Elkton Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Ashville N.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Earl S. Thompson</u>		ADDRESS <u>Rising Sun, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Thoms</u>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

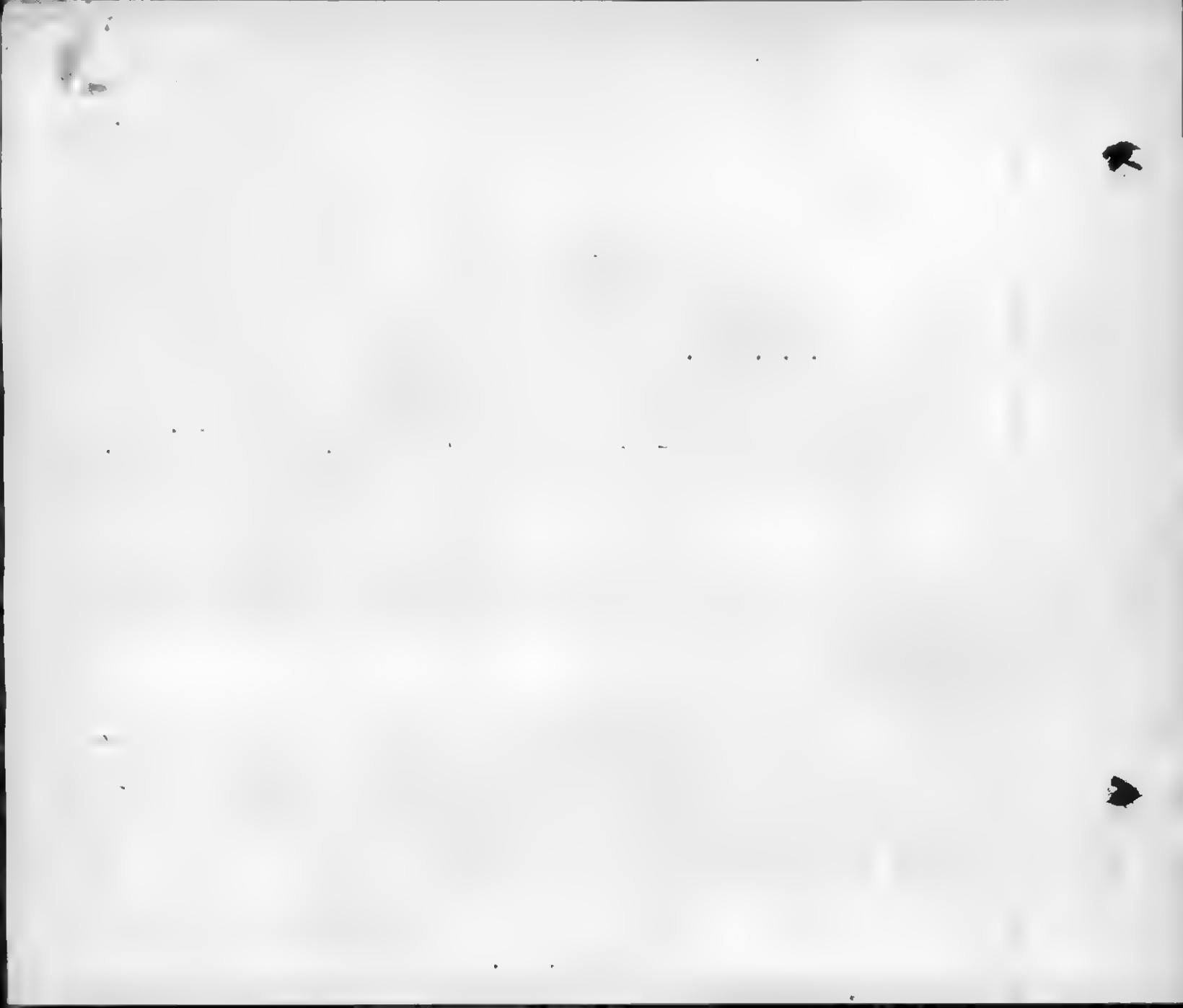
10241

Reg. Dist. No

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RD 3</u>		e. STREET ADDRESS <u>RD 3</u>	
3. NAME OF DECEASED (Type or print) <u>Ellen Donnell Smith</u>		4. DATE OF DEATH <u>September 26</u> 19 <u>58</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 9, 1900</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary (A.P.G.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Us. Gov't</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Donnell Smith</u>		14. MOTHER'S MAIDEN NAME <u>Maude Evans</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-01-1319</u>	
17. INFORMANT <u>Margaret Clark,</u>		Address <u>R.D. #3, Aberdeen, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive CV disease</u>			
443X DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald E Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md.</u> DATE SIGNED <u>9-27-58</u>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/29/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Spesutia Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Perryman, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Harring</u>		ADDRESS <u>Aberdeen, Md.</u>	
24a. REC'D BY REGISTRAR <u>SEP 30 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



10233

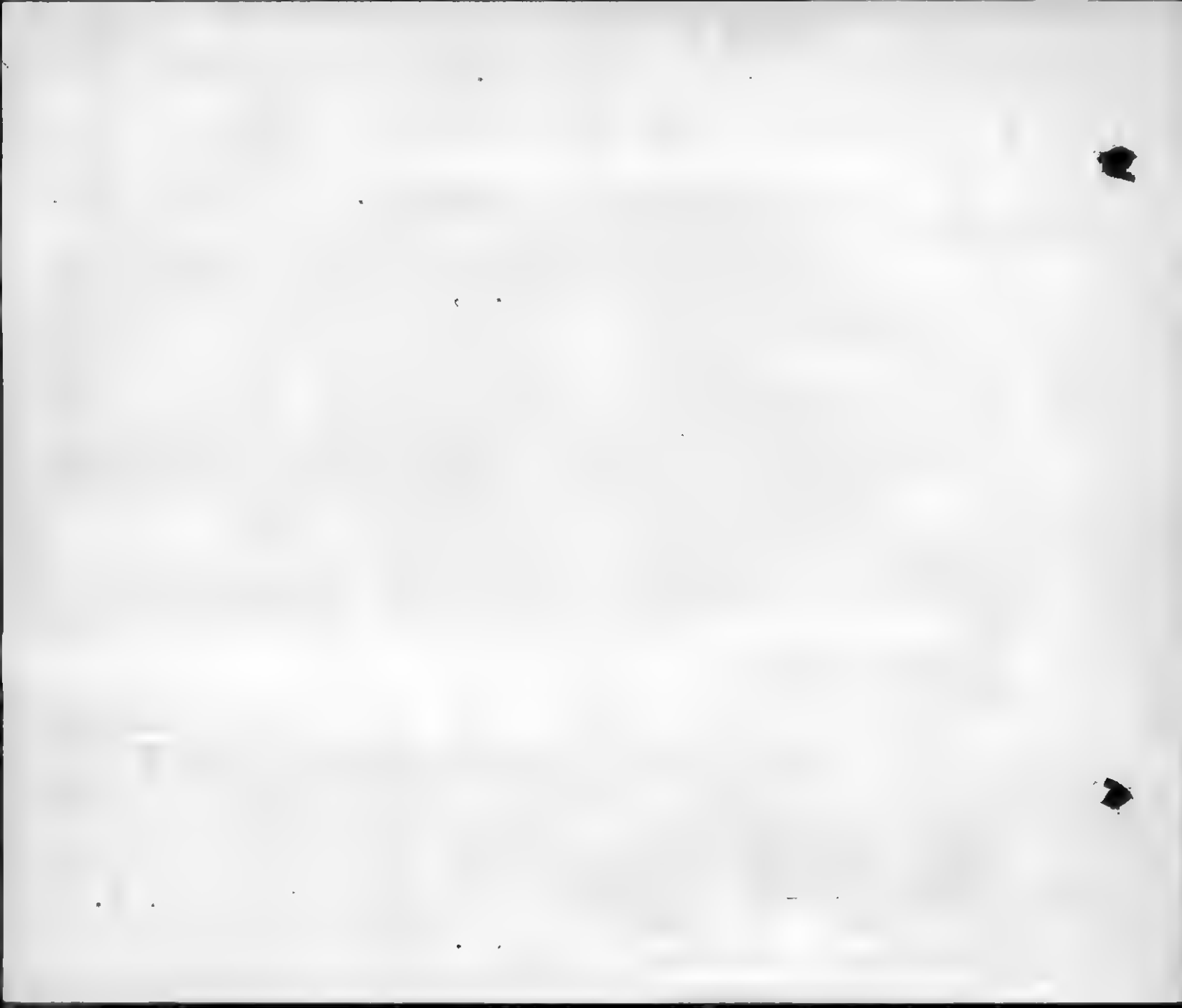
CERTIFICATE OF DEATH

10229

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				d. STREET ADDRESS <u>Aikin Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>P.</u> Last <u>Stephenson</u>				4. DATE OF DEATH Month <u>September</u> Day <u>9</u> Year <u>1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 22, 1906</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trainman, R.R.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Passenger</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>John S. Stephenson</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Owens</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>717-07-5859</u>		17. INFORMANT <u>Ruth Stephenson (wife)</u> Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>9.11X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month <u>Sept</u> Day <u>9</u> Year <u>1958</u> Hour a. m. <u></u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u> (County) <u></u> (State) <u></u>							
21. I certify that I attended the deceased from <u>Sept 9 - 1958</u> to <u>Sept 9 - 1958</u> , that I last saw the deceased alive on <u>Sept 9 - 1958</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clarence I. Benson</u> M.D.				ADDRESS (Street, city or town, state) <u>Perryville, Md.</u> DATE SIGNED <u>9/9/58</u>			
PHYSICIAN'S NAME (Type) <u>CLARENCE I. BENSON</u>							
22a. BURIAL, CREMATION, REBURY (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-12-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Principio</u>		22d. LOCATION (City, town, or county) (State) <u>Principio Furnace, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Veera Patterson & Son</u> ADDRESS <u>Perryville, Md.</u>				24a. REC'D BY REGISTRAR <u>SEP 11 '58</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

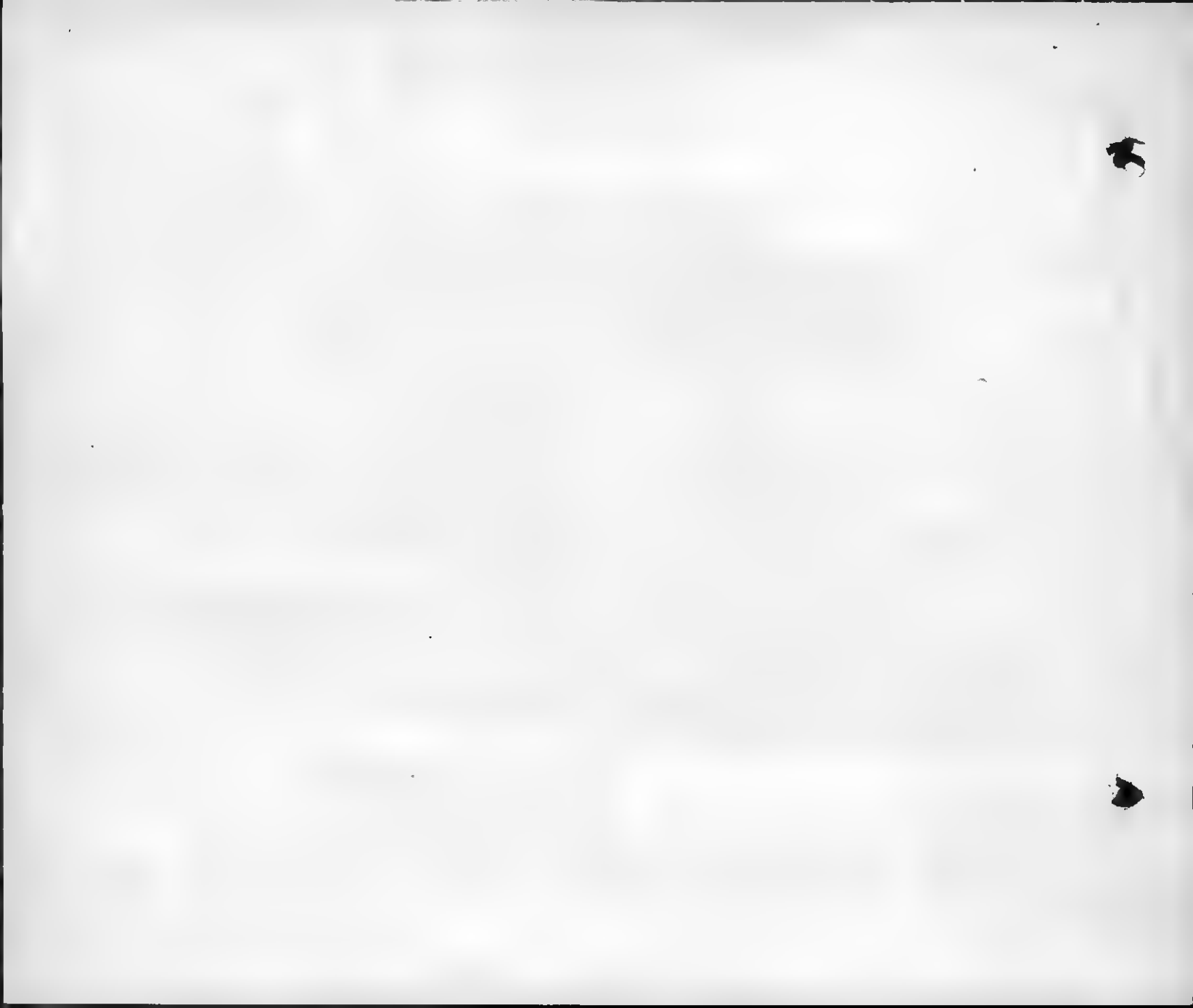
10242

CERTIFICATE OF DEATH

10230

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before adm ssion) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tarrettsville</u>		c. LENGTH OF STAY IN 1b <u>38 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Tarrettsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thomas-Clarence Street</u>				4. DATE OF DEATH Month Day Year <u>Sept-7-1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Sept-5-1866</u>	9. AGE (In years last birthday) <u>92</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter & Decorator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore City</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Streett</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Seymore</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Clarence E Streett Tarrettsville Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerosis, generalized</u> DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardio decompensation</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JUNE</u> , 19 <u>57</u> , to <u>7 Sept</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7 Sept</u> , 19 <u>58</u> , and that death occurred at <u>11:55 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Thos. A. E. Moseley Jr. M.D.</u>							
PHYSICIAN'S NAME (Type) <u>Thos. A. E. MOSELEY, JR. M.D.</u> <u>TARRETTSVILLE, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Sept 10-58</u>		<u>Tarrettsville</u>		<u>Tarrettsville, Harford Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin Skutitz</u>				ADDRESS <u>Jane Woodie</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 15 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>C. J. K. K...</u>	



10243

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Harford MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. LENGTH OF STAY IN 1b 24 Hayre de Grace	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US ARMY HOSPITAL ABERDEEN PROVING GROUND, MD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF (Type or print) First Middle Last WILLIAM ANDREW SWACK		4. DATE OF DEATH Month September Day 12 Year 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 11, 1958
9. AGE (In years last birthday) yrs. 7		IF UNDER 1 YEAR IF UNDER 24 HRS Months 7 Days 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Gary Andrew Swack		14. MOTHER'S MAIDEN NAME Dorothy Ann Murez	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO N/A	
17. INFORMANT Father		Address 353 Congress Ave Hayre de Grace, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 76x DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 7 hrs 15 min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1900 hrs 11 Sep 58 to 0215 hrs 12 Sep 58 that I last saw the deceased alive on 12 September 1958 and that death occurred at 2:15A M , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Joseph N. Silverstein M.D.		DATE SIGNED 12 Sep 58	
PHYSICIAN'S NAME (Type) JOSEPH N SILVERSTEIN CAPT MC		USAH APG MD	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 9/15/58	22c. NAME OF CEMETERY OR CREMATORY Aberdeen Proving Ground	22d. LOCATION (City, town, or county) (State) Aberdeen Proving Ground MD
23. FUNERAL DIRECTOR'S SIGNATURE Forrestor Rm		24a. REC'D BY REGISTRAR SEP 16 '58	24b. REGISTRAR'S SIGNATURE C. J. S. K...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

INSTRUCTIONS

1 The law requires that the death certificate be executed within 72 hours after death. After this time, the bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the bottom copy may be retained by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly must be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10232

10244

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Street</u>				TOWN <u>Street</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Mao</u> (Middle) <u>H. Anderson</u> (Last) <u>Townsley</u>				(Month) <u>9</u> (Day) <u>17</u> (Year) <u>19 58</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 13/1899</u>	9. AGE last birthday <u>59</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS
				Months		Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife at Home</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Harford Co. Md.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>							
13. FATHER'S NAME <u>Arthur Ruff</u>				14. MOTHER'S MAIDEN NAME <u>B. Leita Chamberlain</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) <u>in</u>				16. SOCIAL SECURITY NO. <u>0213-16-1073</u>		17. INFORMANT & ADDRESS <u>Mrs. Amor Little</u>	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Diabetes Mellitus</u>				<u>10 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 1</u> , 19 <u>47</u> , to <u>Sept. 16</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>September 16 58</u> , and that death occurred at <u>12:45 PM</u> , from the causes and on the date stated above							
SIGNATURE <u>Robert Barthel</u> M.D.				ADDRESS (Street, city, town, state) <u>Forest Hill, Maryland</u>		DATE SIGNED <u>9-17-58</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Sept. 20, 1958</u>		NAME OF CEMETERY OR CREMATORY <u>Rubler Cem</u>		LOCATION (City, town, or county) <u>Harford Co. Md.</u>	
24. REC'D BY REGISTRAR <u>SEP 23 '58</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>		ADDRESS <u>Harford</u>	



1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit, Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Charles Carroll Vance</u>		4. DATE OF DEATH Month <u>9</u> Day <u>28</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-19-1876</u>
9. AGE (In years last birthday) <u>82</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor, PowerHouse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Edward Vance</u>		14. MOTHER'S MAIDEN NAME <u>Margaretta Dunmore</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>164-10-6470</u>	
17. INFORMANT <u>Marguerite Boyer (sister)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Recto-Vesical Fistula</u> DUE TO (c) <u>Prostatism & Retention</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9/13</u> , 19 <u>58</u> , to <u>9/28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9/28</u> , 19 <u>58</u> , and that death occurred at <u>6:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George J. Stansbury</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>9/30/58</u>	
PRINTED NAME (Type) <u>George T. Stansbury</u>		M.D. <u>569 Revolution St. Havre de Grace, Md.</u>	
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Buried</u>	22b. DATE THEREOF <u>10-2-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cokesbury Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Port Deposit, Md. Rural</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. A. Patterson & Son</u>		ADDRESS <u>Perryville, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>OCT 1 1958</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. S. Kinn</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10245

CERTIFICATE OF DEATH

10234

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Street Route 2</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Street Route 2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Charles Wm. Walter</u> First Middle Last		4. DATE OF DEATH <u>Sept 22</u> Month Day Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <u>April 19 1887</u> Yrs. Months Days Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Fireman</u>		11. BIRTHPLACE (State or foreign country) <u>Harford Co. Md. U.S.A</u>	
13. FATHER'S NAME <u>Albert L. Walter</u>		14. MOTHER'S MAIDEN NAME <u>Anna H. Grimes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-01-0257</u>	
17. INFORMANT <u>Victor A. Walter</u>		18. INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>422.2</u> IMMEDIATE CAUSE (a) <u>Myocarditis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 12, 1958</u> to <u>Sept 28, 1958</u> , that I last saw the deceased alive on <u>Sept 25, 1958</u> , and that death occurred at <u>24</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>F. P. Snodgrass</u>		DATE SIGNED <u>9-28-58</u>	
PHYSICIAN'S NAME (Type) <u> </u>		ADDRESS (Street, city or town, state) <u>Darlington Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct 1, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Taber</u>	22d. LOCATION (City, town, or county) (State) <u>Harford Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailez</u>		24a. RECD BY REGISTRAR <u>3 58</u>	
ADDRESS <u>Darlington Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 19

1953

FILE NO.

DATE OF DEATH

WEATHER

DEATH
LOCATION

CAUSE OF DEATH
IMMEDIATE CAUSE

UNDERLYING CAUSE
IMMEDIATE CAUSE

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

100-100000-100000

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 1 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 73 Film 6234 9/24/58 ggj

10235

10235

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARTFORD</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>HARTFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BEL AIR</u>		LENGTH OF STAY (in this place) <u>60 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BEL AIR MD</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>7 Lee Street</u>			
3. NAME OF DECEASED (First) <u>HELEN</u> (Middle) <u>B</u> (Last) <u>WATERS</u>				4. DATE OF DEATH (Month) <u>Sept</u> (Day) <u>13</u> (Year) <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Co</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>1876</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Hartford Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Nea</u> <u>B Bond</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>(If Yes, give war or dates of service)</u>		17. INFORMANT & ADDRESS <u>John Waters</u> <u>7 Lee St Bel Air MD</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
1. IMMEDIATE CAUSE (A) <u>CARDIO-RESP. FAILURE</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 MINUTES</u>			
2. ANTECEDENT CAUSE(S) DUE TO (B) <u>ACUTE LEFT VENTRICULAR FAILURE</u>				<u>5 MINUTES</u>			
3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE</u>				<u>6 YEARS</u>			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>—</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>FEB</u> , 19 <u>57</u> , to <u>Sept</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12 Sept</u> , 19 <u>58</u> , and that death occurred at <u>7:30 P</u> .M., from the causes and on the date stated above.							
SIGNATURE <u>J. P. Milwell</u>				ADDRESS (Street, city, town, state) <u>M.D. 401 FRANKLIN ST. BEL AIR, MD</u>			
DATE SIGNED <u>SEP 16 '58</u>				DATE SIGNED <u>14 SEPT 58</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept 16, 1958</u>		NAME OF CEMETERY OR CREMATORY <u>Tahersville</u>		LOCATION (City, town, or county) (State) <u>Bel Air Md</u>	
24. REC'D BY REGISTRAR <u>SEP 16 '58</u>		REGISTRAR'S SIGNATURE <u>Charles S. Evans</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph T. Tinter</u> ADDRESS <u>Bel Air Md</u>			

A24

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH AND HUMAN SERVICES

U.S. GOVERNMENT PRINTING OFFICE

INSTRUCTIONS

1. This form is to be filled out by a physician or other qualified person who has attended the deceased.

2. The information on this form is used for statistical purposes and to determine the cause of death.

3. The information on this form is also used to determine the place of death.

4. The information on this form is also used to determine the time of death.

5. The information on this form is also used to determine the manner of death.